STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-05/09-277
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals the decision by the Department of Disabilities, Aging, and Independent Living (DAIL) to substantiate him for abuse and neglect of a vulnerable adult. The issue is whether DAIL has shown by a preponderance of the evidence that the petitioner abused and neglected a vulnerable adult within the meaning of the applicable statutes. The following decision is based upon the evidence adduced at hearing.

FINDINGS OF FACT

1. The petitioner has been a registered nurse for approximately fifteen years. He received the requisite training to be a nurse in an intensive care unit (ICU). He had nine years ICU experience prior to his employment at Porter Hospital.

2. On September 25, 2008, petitioner was employed as a registered nurse by Porter Hospital in their special care unit (SCU). The SCU is the same as an ICU. At that point,

petitioner had been employed by Porter Hospital approximately nine months. Petitioner is no longer employed by Porter Hospital.

3. Porter Hospital has a three bed SCU comprised of a patient room with two beds, nurse's station in the middle, and a patient room with one bed. There are glass windows between the SCU nurse's station and the two patient rooms. The SCU is located on the same floor as a medical/surgical floor. There is an interior glassed in nursing station for the medical/surgical floor that is approximately twenty to twenty-five feet from the SCU.

4. To be a SCU nurse, a person must complete Advanced Cardiac Life Support (ACLS) to have the requisite skills to care for acute heart patients.

5. At Porter Hospital, the SCU nurse is responsible for both SCU patients and monitoring the telemetry on certain patients on the medical/surgical floor. There are monitors for all these patients in the SCU nursing station; these monitors have an audio alarm system and a visual alarm system. There are a second set of monitors at the medical/surgical nursing station that do not have an audio alarm system but have a visual alarm system. If the door to

the SCU is open, it is possible to hear the alarm from the SCU at the medical/surgical nursing station.

6. On September 25, 2008, petitioner was the SCU nurse on duty.

On September 25, 2008, the medical/surgical ward had a charge nurse and several floor nurses on duty.

7. The precipitating incident occurred on September 25, 2008 at approximately 5:15 p.m.

8. On that day, R.C. was the only patient in the SCU. R.C. was a ninety-five year old post-operative patient who had a cardiac condition; he was a retired doctor who had practiced at the hospital. He was confused. That day, he had a cardiac incident involving a too fast heart rate at approximately 1:00 p.m.

9. R.R. has been a R.N. since 1971. He is the administrative supervisor for the second shift at Porter Hospital and has been in that position for twelve years. He was on duty on September 25, 2008 starting at 3:00 p.m.

R.R. testified that part of his duties are overseeing clinical activities, administrative issues, and staffing issues. He does not ordinarily do direct patient care. He provides back-up for nurses when necessary. When he comes on duty, he receives a report from the preceding administrative

supervisor and does rounds. He receives reports from nurses about their patients.

His expectation is that a SCU nurse will not leave a patient alone but will page him for back-up assistance to either watch the patient or do the errand as well as provide back-up for a bathroom break. Errands can include getting medications or placing rhythm strips in telemetry patient charts. He is not always able to provide back-up. In those instances, he is responsible for finding someone besides the SCU nurse to do the errand, etc.

He acknowledged that although SCU nurses should call him, it does not happen in all instances.

10. On September 25, 2008, R.R. did rounds starting at 3:00 p.m. that included the SCU. He was aware that R.C. was the SCU patient and knew of R.C.'s past affiliation with the hospital. R.R. testified that R.C. appeared confused and that R.C. had tried to get out of bed previously. After his rounds, R.R. took a patient for a CT scan.

When R.R. returned the CT scan patient to the medical/surgical ward, R.R. went to the SCU entering through the SCU nurse's station. At approximately 5:15 p.m., R.R. found R.C. alone in the SCU room trying to get out of bed. The details will be more fully set out below. R.R.

intervened to prevent R.C. from getting out of bed and falling. Petitioner returned to the SCU shortly thereafter with a unit of blood from the lab for R.C.

11. Patients are assessed daily for risk of falling. Bed alarms are used if there is a risk of the patient falling. The bed alarm on R.C.'s bed was not on at approximately 5:15 p.m. that day. The bed alarm had been on earlier but had been turned off by petitioner in the late afternoon when petitioner repositioned R.C. in his bed.

12. According to petitioner, there was no emergent need for the unit of blood for R.C.

13. On September 25, 2008, R.R. called R.P. immediately after the incident and then wrote a letter to R.P. setting out what happened, his concerns, and asking R.P. to look into the incident. R.P. was and is the Medical/Surgical and SCU Nurse Manager. R.R. testified that he made the report because he was concerned about the patient being left alone.

In his written report, R.R. described R.C.'s bed as elevated. R.R. described R.C. as confused with his various wires and tubes tangled in his grasp, and about to fall out of bed. R.R. quickly intervened to position R.C. in bed. The petitioner was not in the SCU. He noted that the petitioner returned after the incident with a unit of blood

for R.C. and that petitioner explained he left the SCU to get blood from the lab. (The lab is one floor lower than the SCU and Medical/Surgical ward.) R.R. characterized the incident as "potentially catastrophic" and that petitioner did not exercise good judgment.

14. R.R. testified that he came to the SCU at approximately 5:15 p.m. The door to the SCU nurse's station was open. He looked into R.C.'s room and saw that R.C.'s legs were over the left side of the bed and R.C. was about to go forward. R.R. testified that he sprinted into the room to prevent R.C. from falling and than settled R.C. back in bed.

R.R. testified that the bed was approximately three feet high; he characterized three feet as an elevated position. He testified that the bed should have been in a lower position. R.R. testified that the bed alarm was not on. He testified that he expected the bed alarm to be on given the patient's risk of falling.

C.B., the charge nurse for the medical/surgical ward, came in after R.R. had repositioned R.C. and asked where petitioner was because she had a telephone call for petitioner from a doctor asking for the SCU nurse. Thirty seconds later, petitioner came in with a unit of blood. R.R. asked petitioner why he left and was told that petitioner had

gone to the lab for a unit of blood. R.R. testified that he told the petitioner that leaving R.C. alone was unacceptable.

R.R. learned that day from C.B. that petitioner asked for her assistance and that C.B. offered to go to the lab. It is not clear from R.R. whether he learned this information when C.B. came into the SCU or later.

15. C.B. was the charge nurse on the medical/surgical ward on September 25, 2008 from 3:00 p.m. to 11:00 p.m. As charge nurse, C.B. oversees the patients and nurses attending to those patients. Her ward ordinarily has twelve to thirteen patients. A medical/surgical floor nurse is assigned to each patient and provides primary care for that patient.

C.B. has been a registered nurse since 1987. She has been at Porter Hospital for over one year. At the time of the incident, she did not have ACLS certification. As a result, she was not qualified to watch SCU patients and was not permitted to do so. Petitioner was aware that C.B. was not ACLS certified. When requested by a SCU nurse, C.B. and other nurses can assist by helping to reposition patients with the SCU nurse, going to the lab for blood for SCU patients, etc.

16. C.B. testified that when R.R. returned to her unit later on September 25, 2008, he asked her to write a statement about what she knew to R.P. while the information was still fresh in her memory. R.R. is C.B.'s supervisor.

17. C.B. wrote a statement to R.P. dated September 26, 2008. C.B. wrote the following:

> [petitioner] stated "he had to go to the lab to get blood" I told him that I was more than willing to go & get the blood for him and he stated "no, no that's alright I'll take care of it" I further mentioned that he had a pt in the unit & I was willing to help and he just walked away...and headed towards the SCU.

She wrote that about fifteen minutes later, she received a telephone call from a doctor for the SCU nurse. She attempted to put the call through but it bounced back to her two times and she told the doctor she thought the SCU nurse was tied up and that she would check the SCU and deliver the message. She went to the SCU, saw R.R. with the patient, gave the phone message, and went back to her station.

In her testimony, C.B. testified that she put the petitioner's words in quote marks because they were his exact words, but she did not put her statements in quote marks because they were not her exact words.

C.B. was questioned about the meaning of her written statement that "she was willing to help". C.B. testified

that her statement meant that she was willing to help by getting blood.

18. C.B. testified that she did not agree to watch R.C. while petitioner went to the lab. C.B. said she was not then ACLS certified and that she had no responsibility for the SCU. C.B. understands that taking responsibilities for SCU patients without the proper certification and education is problematic. In her testimony, C.B. testified to the chain of events in her written statement. She testified that when petitioner left and walked down the hallway; she did not know that he was going to the lab for blood even though petitioner said he planned to get the blood himself. She went back to her work.

C.B. testified that she was not responsible for petitioner. C.B. acknowledged that it would be problematic to not report that a SCU nurse left a patient unattended if she had that information.

19. R.P. is the nurse manager for the medical/surgical and SCU wards at Porter Hospital. She has been so employed for 8 years. She became a registered nurse in 1990. She is responsible for a total of 42 employees including 5 SCU nurses.

20. R.P. became involved in R.C.'s patient care on September 25, 2008. She relieved petitioner when he went on his lunch break. R.C. had a faster heart rate than expected and needed to be stabilized. This occurred approximately at 1:00 p.m. Petitioner returned from lunch, but R.P. stayed to help stabilize R.C. She stayed in the SCU for approximately three hours and left at 4:00 p.m. Before R.P. left, she asked petitioner if he was okay with her leaving and he was okay with her leaving.

21. R.P. testified regarding her observations of R.C. She stated that R.C. was confused, unable to go to the bathroom independently, take his medications on his own, unable to feed himself, and unable to ambulate safely. She believed that R.C. needed constant monitoring. R.P. stated that the SCU nurse did not need to have eyes on R.C. all the time but needed to be close enough to understand what was happening to R.C.

22. R.P. testified that Porter Hospital has unwritten practice policies that if a SCU nurse needs to leave the unit, the SCU needs to call a supervisor or unit leader to arrange for coverage or to have the supervisor arrange to have the errand covered either personally or by delegation.

She testified that new SCU nurses go through a three month orientation that includes shadowing preceptors.

She also testified that it is possible to leave a patient for a few minutes to pick up medications or chart a rhythm strip if the patient was stable. R.P. did not believe that R.C. would be in that category. She did not believe that the period from R.C.'s heart episode until 5:00 or 5:15 p.m. was of sufficient length to document stability.

23. R.P. was called at home by R.R. on September 25, 2008 at approximately 5:15 p.m. R.R. reported that petitioner left R.C. unattended and unsafe. She testified that R.R. told her that C.B. had offered petitioner to get the blood for R.C..

24. R.P. spoke with C.B. by telephone on the morning of September 26, 2008 because she wanted to know about C.B.'s involvement. She testified that C.B. told her about her offer to get the blood for R.C., but that petitioner declined and said he would do so himself. R.P. did not see C.B.'s written statement prior to this conversation.

25. R.P. met with petitioner on September 26, 2008 in the presence of a HR manager. She made a written contemporaneous record of her meeting. In those notes, she wrote that petitioner said C.B. did not offer to get the

blood for R.C., that he did not ask C.B. to go into the SCU to monitor R.C. but believed she would do so, that he did not call R.R. because R.R. was with another patient, and that he thought R.C. was asleep and stable when he left the SCU for two to three minutes. He agreed that it was not imperative for R.C. to have the blood. He said he realized he had not used good judgment.

26. The matter was reported to Adult Protective Services (APS) on or about November 3, 2008. L.D., an APS investigator, was assigned the case. L.D. has been a civil investigator for five years. She was a case manager for a local council on aging prior to her work with APS. She testified that there was little difference between her job as a case manager and her job as an APS investigator.

L.D. interviewed R.R. and C.B. in person. She spoke to R.P. and the petitioner by telephone. She does not believe there is any difference between interviewing a person in person or by telephone.

L.D. explained to petitioner the purpose of her telephone call. She testified that petitioner did not deny leaving R.C. alone in the SCU but stated that he believed C.B. would watch R.C. She does not remember whether she told

petitioner he could be interviewed in person. She had one short telephone conversation with petitioner.

She did a site visit and ascertained that the SCU was not visible from the nurse's station in the medical/surgical ward.

L.D. was told that a SCU patient should not be left unattended. She understood that R.C.'s plan of care included not being left unattended but did not see R.C.'s plan of care. L.D. recommended substantiation to her supervisor. L.D. testified that leaving a critical care patient alone for any period of time left the patient at risk of harm.

27. J.F. has been the APS chief for the past nine months. Prior to that time, she was an APS investigator for nine months and a Family Services Department investigator for thirteen years in Vermont. She testified that she was asked after the commissioner's reviewer spoke to petitioner to follow up with R.R. whether he knew if C.B. was ACLS certified at the time of the incident and to follow up with C.B. to explain what she meant in her September 26, 2008 statement when she wrote that she offered to help petitioner. J.F. testified that R.R. told her he knew C.B. was not ACLS certified at the time of the incident. J.F. testified that C.B. told her that C.B. offered to get the blood.

28. The petitioner testified regarding the practices at Porter Hospital. He stated that he was trained by a preceptor and followed her example. He explained that there were occasions when he left patients unattended in the SCU to do certain tasks including placing the rhythm strips on the charts of medical/surgical patients on telemetry, picking up medications at PXS, or using the bathroom. All these activities kept him on the same floor as the SCU. When placing rhythm strips in charts, he had access to the monitors at the medical/surgical nursing station. He also testified that he had picked up units of blood from the lab before without backup. He testified that he never heard of anyone calling for backup to get supplies or use the bathroom.

29. The petitioner testified that R.C. came into the SCU on September 25, 2008 when petitioner was on break for lunch. Petitioner started his twelve hour shift at 6:45 a.m. Petitioner returned from lunch to find that R.C. had an elevated heart rate and his blood pressure was not under control. Medications were used to stabilize R.C.'s heart rate and blood pressure. Petitioner did agree that R.C. was confused.

After 4:00 p.m., R.C. fell asleep. Petitioner testified that R.C. was not in a comfortable position so he asked C.B. to help him reposition R.C. To do so, the petitioner turned off the bed alarm and raised the bed about six inches so that he and C.B. could physically lift R.C. without back strain. Petitioner testified that the bed was three feet high when they were done repositioning the patient. The bed alarm was not turned back on. Petitioner testified that there are times when two people reposition a patient that each thinks the other has turned back on the alarm. R.C. was petitioner's patient and it was petitioner's responsibility to make sure the bed alarm was turned on.

Petitioner testified that he received a telephone call from R.C.'s doctor asking whether the blood transfusion had been done. The doctor indicated the transfusion was not emergent but should be done soon.

Petitioner testified that R.C. was asleep and stable in that his heart rhythm and blood pressure were stable. Petitioner testified the he knew R.R. had taken a patient for a CT scan and was not available. He left the SCU to speak to C.B. at the medical/surgical nursing station to ask her to watch R.C. while he went to the lab for a unit of blood. His decision to ask for back-up is an acknowledgment that R.C.

should not be left without monitoring. Petitioner was aware that C.B. was not ACLS certified.

Petitioner testified that he asked C.B. to keep an eye on R.C. while petitioner went to the lab. C.B. asked whether it would not be easier if she got the blood. Petitioner testified that he told her the patient was asleep and stable and that she had many patients and that he only had one patient and that he would be very quick. Petitioner testified that C.B. agreed to keep an eye on R.C. and that he left for the lab. He testified that he believed C.B. would check his patient every couple minutes until he returned.

Petitioner testified that he was gone less than five minutes for the blood. When he returned, he found R.R. with R.C. R.R. asked petitioner where he had been; petitioner replied that he went to the lab for blood and that he asked C.B. to keep an eye on his patient.

30. Petitioner testified that he was interviewed by L.D. about the incident. He testified that the telephone interview took approximately two to three minutes.

ORDER

DAIL's decision is affirmed.

REASONS

The Commissioner of the Department of Aging and Independent Living (DAIL) is required by statute to investigate allegations of abuse, neglect or exploitation of vulnerable adults, and to keep those records that are substantiated in a registry under the name of the person who committed the abuse. 33 V.S.A. §§ 6906 and 6911(b). The statute's purpose is to "protect vulnerable adults whose health and welfare may be adversely affected through abuse, neglect or exploitation". 33 V.S.A. § 6901. There is no argument that R.C. met the definition of a vulnerable adult during his hospitalization under 33 V.S.A. § 6902(14)(D).

If a report has been substantiated, the person who has been found to have committed abuse/neglect/exploitation may apply to the Human Services Board for relief that the report is not substantiated. 33 V.S.A. § 6906(d).

The definitions for abuse, neglect, and plan of care are set out in 33 V.S.A. §§ 6902 (1),(7) and (8); the pertinent sections state:

(1) "Abuse" means:

> (A) Any treatment of a vulnerable adult which places life, health or welfare in jeopardy or which is likely to result in impairment of health;

> (B) Any conduct committed with an intent or reckless disregard that such conduct is likely to cause unnecessary harm, unnecessary pain or unnecessary suffering to a vulnerable adult;
>
> ...
>
> (7) "Neglect" means purposeful or reckless failure or omission by a caregiver to:
>
> (A)(iii) carry out a plan of care for a vulnerable adult when such failure results in or could reasonably be expected to result in physical or psychological harm or a substantial risk of death to the vulnerable adult, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative, or a terminal care document, as defined in subchapter 2 of chapter 111 of Title 18; ...
>
> (B) Neglect may be repeated conduct or a single incident which has resulted in or could be expected to result in physical or psychological harm, as a result of subdivisions (A)(i)(ii) or (iii) of this subdivision (7).
>
> (8) "Plan of care" includes, but is not limited to, a duly approved plan of treatment, protocol, individual care plan, rehabilitative plan, plan to address activities of daily living or similar procedure describing the care, treatment or services to be provided to address a vulnerable adult's physical, psychological or rehabilitative needs.

DAIL has the burden of proof to show that petitioner's behavior meets the criteria for abuse and/or neglect by a preponderance of evidence. The Board has found that one act alone can rise to the level of abuse. Fair Hearing No. 20,389. In addition, one act alone can meet the definition of neglect. 33 V.S.A. § 6902(7)(B).

Each case turns on its specific facts. The Board, in its analysis, has differentiated behavior that is reckless from behavior that is unnecessary, inappropriate, or unprofessional. Fair Hearing No. B-09/08-414. The focus in this case is petitioner's responsibilities towards R.C.

Petitioner was aware that R.R. was not available for back-up when he decided to get a unit of blood from the lab, so he sought other back-up by approaching C.B. to watch his patient. Even accepting petitioner's testimony that C.B. agreed to watch R.C., petitioner was aware that C.B. was not qualified to care for a SCU patient. He was also aware that the need for blood was not urgent. Petitioner could have waited to get the blood until qualified back-up was available or he could have let C.B. get the blood.

Equally important, we need to consider R.C.'s condition. R.C. was a ninety-five year old post-operative patient. R.P.'s testimony is important because she attended R.C. when petitioner was at lunch (approximately 1:00 p.m.) and when R.C. experienced a cardiac episode. Once petitioner returned from lunch, R.P. continued to care for R.C. alongside petitioner until 4:00 p.m. when she left the SCU. She found that R.C. was confused, not able to ambulate safely, and not able to feed himself or take his medications. Although his

cardiac condition was stabilized, that alone does not change that R.C. was confused and unable to ambulate safely. R.R. was first aware of R.C. when he did his rounds at 3:00 p.m. R.R. knew that R.C. was confused and had tried to get out of bed previously. In addition, the fact that a bed alarm was ordered for R.C. is a tacit acknowledgment that R.C. was at risk of falling.

Petitioner's actions in light of his professional responsibilities are the key consideration. The salient factors are:

1. Petitioner did not ensure that the bed alarm was reconnected after repositioning R.C.

2. R.C. was confused and at risk for falling.

3. Petitioner did not have to obtain the unit of blood at that time.

4. Petitioner's actions to ask C.B. for back-up acknowledge the need for someone to check on R.C. periodically.

5. Petitioner knew that C.B. was not qualified to monitor a SCU patient.

6. Petitioner could have accepted C.B.'s offer to get the blood.

7. The medical/surgical ward had several floor nurses to cover medical/surgical patients while C.B. went to the lab.

In light of the above, petitioner showed a lack of judgment in his care of R.C. He did not ensure that R.C. was

adequately monitored but left R.C. alone for at least five minutes.

Fortunately, R.C. was not actually harmed because R.R. happened into the SCU at the moment when R.C. was trying to get out of bed. Given R.C.'s condition, it is likely that he would have fallen and injured himself.

Although R.C. was not injured, the inquiry does not stop because the statute includes actions that place a vulnerable adult at risk of physical harm. When petitioner left R.C. alone without adequate back-up, petitioner placed R.C. at risk of such harm.

DAIL has shown by preponderance of evidence that petitioner is substantiated for abuse and neglect of a vulnerable adult. DAIL's decision is affirmed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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